INTERNAL MEDICINE PHYSICIANS P.C.
& FAMILY PHYSICIANS

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**		
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
Previous or referring doctor:		**Date last seen by previous Dr:**			
Pharmacy:		**Date of last physical exam:**			

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Other:			
Immunizations and date last received:	☐ Tetanus		☐ Pneumonia	
	☐ Hepatitis		☐ Chickenpox	
	☐ Influenza		☐ MMR (*Measles, Mumps, Rubella)*	
	☐ Shingles		☐ Other:	

List any medical problems that other doctors have diagnosed	

List any specialists you have seen (past or present)

Surgeries/Procedures		
Year	Reason	Location
	Cardiac Stress Test	
	EKG	
	Colonoscopy	
	PSA	
	Pap Smear	
	Mammogram	

List your prescribed medications as well as over-the-counter medications (such as vitamins and inhalers) ***USE BACK IF NEEDED***		
Name of Medication	Dose	Frequency Taken
Allergies to Medications ***PLEASE LIST NON-MEDICATION ALLERGIES ON BACK OF PAGE*		
Type	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)						
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)						
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)						
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)						
Diet	Are you "dieting"?					☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?					☐ Yes	☐ No
	How would you describe your diet?						
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	# of cups/cans per day?		
Alcohol	Do you drink alcohol?					☐ Yes	☐ No
	If yes, what kind?						
	How many drinks per week?						
	Are you concerned about the amount you drink?					☐ Yes	☐ No
	Have you considered stopping?					☐ Yes	☐ No
Tobacco	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day			
	☐ # of years	☐ Or year quit					
Drugs	Do you currently use "recreational" or "street drugs"? Type:					☐ Yes	☐ No
	Have you used "recreational" or "street drugs" in the past? Type:					☐ Yes	☐ No
Personal Safety	Do you live alone?					☐ Yes	☐ No
	Do you have frequent falls?					☐ Yes	☐ No
	Do you have vision or hearing loss?					☐ Yes	☐ No
	Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?					☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?				☐ Yes ☐ No
Do you feel depressed?				☐ Yes ☐ No
Do you panic when stressed?				☐ Yes ☐ No
Have you ever attempted suicide?				☐ Yes ☐ No
Have you ever seriously thought about hurting yourself?				☐ Yes ☐ No
Do you have trouble sleeping?				☐ Yes ☐ No
If yes,	☐ Insomnia	☐ Snoring	☐ Sleep Apnea	☐ Other:

ADVANCED DIRECTIVE

Do you have an advanced directive or living will?	☐ Yes ☐ No

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Sign: _____

Date: _____